

Form MCSA-5875		OMB No.: 2126-0006 Expiration Date: 03/31/2025	
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U.S. Department of Transportation Federal Motor Carrier Safety Administration		Medical Examiner's Certificate <small>(For Commercial Driver Medical Certification)</small>	
I certify that I have examined (last name) <u>Gossell</u> (first name) <u>Erik</u> In accordance with (please check only one): <input checked="" type="radio"/> the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) OR <input type="radio"/> the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply): <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Wearing corrective lenses <input type="checkbox"/> Wearing hearing aid </div> <div> <input type="checkbox"/> Accompanied by a waiver/exemption (specify type) _____ <input type="checkbox"/> Accompanied by a Skill Performance Evaluation (SPE) Certificate </div> <div> <input type="checkbox"/> Driving within an exempt Intra-city zone (49 CFR 391.62) (Federal) <input type="checkbox"/> Grandfathered from State requirements (State) </div> </div>			
The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.			Medical Examiner's Certificate Expiration Date <div style="border: 1px solid black; padding: 2px; display: inline-block;">12/23/2026</div>
Medical Examiner's Signature 		Medical Examiner's Telephone Number (603) 430-9675	
Medical Examiner's Name (please print or type) Stephanie Andrade, NP		Date Certificate Signed 12/23/2024	
Medical Examiner's State License, Certificate, or Registration Number 068079-23		<div style="display: flex; justify-content: space-between;"> <div> <input type="radio"/> MD <input type="radio"/> Physician Assistant <input checked="" type="radio"/> Advanced Practice Nurse <input type="radio"/> DO <input type="radio"/> Chiropractor <input type="radio"/> Other Practitioner (specify) _____ </div> <div> Issuing State New Hampshire </div> <div> National Registry Number 1171992694 </div> </div>	
Driver's Signature 		Driver's License Number NHL16897802	
Driver's Address Street Address: 63 October Lane City: Gifford State/Province: NH Zip Code: 03249		Issuing State/Province New Hampshire	
		CLP/CDL Applicant/Holder <input type="radio"/> Yes <input checked="" type="radio"/> No	

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